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ABSTRACT

A description is provided of a third-year registered nursing course entitled "The History and Physical," designed to help the student acquire knowledge and skills in the areas of taking the history of an individual and physical assessment. The opening sections present information on course prerequisites, grading procedures, and meeting times; identify long-term goals and objectives; list course units and instructional materials; and provide a glossary of terms. Next, information is presented on the individual course units: communication skills; interviewing and nurse-patient relationships; taking an individual's history; psychosocial evaluation; general survey; tests; indication and results; assessments of integumentary system; head and neck; thorax and lung; heart; breast, axillae, and abdomen; back, extremities, and musculoskeletal system; neurological assessment; and genito-urinary and pediatrics assessments. Each unit contains student goals and objectives and assigned media; and examples of mid-term and final examinations are presented. The next sections provide guidelines for video-taping the taking of a medical history; for history taking, examination, and assessment skills; and for demonstration of physical examination/assessment skills. The final sections provide information on grading, class evaluation, and revision procedures. A bibliography is included. (HB)

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NURSING 450

THE HISTORY AND PHYSICAL

Lynn Whalley
California State University, Seal Beach
March 1983

JC 830 545

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Course Description

The purpose of this course is to help the student acquire knowledge and skills in the areas of history taking and physical assessment. This includes different methods of data collection and recording. The course will also cover communication and interactional skills.

This course in history and physical taking is part of the undergraduate registered nursing curriculum. It is a required course for graduation. The course is intended to be taken during the third year, either semester, of the program. Each student enrolling in this course must meet the following qualifications.

Prerequisites:

Courses in Anatomy and Physiology, Chemistry, and Microbiology

Nursing 400 and 405

Consent of instructor

Corequisites:

Biology 445: Pathophysiology

At the completion of this course the student should possess knowledge and skills that will be helpful in passing the state board licensing examination. This information will also be vital to the functioning of the individual as as RN.

It is the hope of the instructor that 100% of the students taking this course will successfully complete it.

The students must, however, complete all of the objectives as specified and obtain a letter grade of C or better. The history of this course shows an average enrollment of 20 to 25 students. Drop out mid-semester averages 5%, and of those remaining successful completion averages 95%

Time assignment:

Lecture: 3 hours every week

Wednesday 9-12 AM

The student must be prepared to spend time outside of class for readings and media assignments to be done. There will also be project assignments to be completed. There is one video-taping session that will have to be done and scheduled outside of class time.

Course Contents

It is a major goal of universities to prepare its students for entry into professions. By concentrating ones educational base in one area, the student can gain knowledge sufficient to enter a profession prepared and competent.

The nursing department has developed its program to fulfill this large goal of the university. The courses are designed and sequenced to enable a student to enter the role of registered nurse. It is necessary to pass a state licensing board examination in order to practice. The nursing curriculum is directed toward achievement of this. In addition the curriculum is directed toward competence and confidence in ones nursing practice ahead.

This course in history taking and physical assessment is among those in the nursing curriculum which will help the student achieve the above stated goal. The initial interaction with a patient is when the history and physical take place. This forms the base of all nursing action that is to occur. Physical assessment is also an ongoing process throughout the patients care, used to alter care as needed. These two functions, history taking and physical assessment, are vital to the practice of nursing.

Long-Range Course Goals

1. The student will understand and be able to apply the

process of history taking and recording in her/his practice of nursing.

2. The student will be able to perform, with knowledge and understanding, a complete physical examination on the patients encountered in her/his practice.

The above long-range goals will be assessed for successful accomplishment by the following long-range course objectives.

1. Of the students completing this course 75% will be performing admission physicals on new patients in their area of nursing practice. This physical exam will consist of at least the procedures of observation and auscultation. Success of this objective will be reported by the students supervisor on an evaluation of work performance done at one year.

2. Of the students completing this course and going into practice 75% will be doing complete admission health histories on new patients. To perform this the student will interview the patient and completely fill out the history form used in the institution for which he/she works. Success will be determined by the supervisor on the one year evaluation.

3. Of the students who complete this course and enter into nursing practice, 80% will be given ratings by their supervisor after six months of above average or superior in the area of patient assessment to the average newly graduated nurse working in that area.

Units

Unit 1 Week 1	Communication Skills
Unit 2 Week 2	Interviewing and Nurse-Patient Relationship
Unit 3 Week 3	History Taking
Unit 4 Week 4	Psychosocial Evaluation
Unit 5 Week 5	General Survey
Unit 6 Week 6	Tests: Indication and Results
Week 7	Mid-term Examination
Unit 7 Week 8	Assessment of Integumentary System
Unit 8 Week 9	Assessment of Head and Neck
Unit 9 Week 10	Assessment of Thorax and Lung
Unit 10 Week 11	Assessment of Heart
Unit 11 Week 12	Assessment of Breast, Axillae, and Abdomen
Unit 12 Week 13	Assessment of Back, Extremities, and Musculo-skeletal System
Unit 13 Week 14	Assessment of Neurological
Unit 14 Week 15	Assessment of Genitourinary
Unit 15 Week 16	Assessment of Pediatrics
Week 17	Final Examination

Materials of Instruction

Required Texts:

Bernstein, L., Bernstein, R.S., and R.H. Dana. Interviewing: A Guide for Health Professionals Appleton-Century-Crofts, NY, NY, 1974.

Bates, Barbara. A Guide to Physical Examination, J.B. Lippincott Co. Philidelphia, PA, 1979.

Stromborg, M.F. Primary Care Assessment and Management Skills for Nurses: A Self-Assessment Manual, J.B. Lippincott Co. Philadelphia, PA, 1979.

Sundeen, S.J., Stuart, G.W., Rankin, E.D., and S.P. Cogen, Nurse-Client Interaction: Implementing the Nursing Process, C.V. Mosby Co. St. Louis, Miss. 1976

Other readings and audio-visual materials are listed with each separate unit. These are available on two-hour reserve in the Nursing Learning Lab. There is also a bibliography of further materials listed at the back of this outline.

Glossary

1. Assessment: Evaluation of a patient's total clinical picture presented, includes physical and psychosocial.

2. Chief Complaint: Description of the patient's reason for seeking medical care.

3. Communication: The act of transmitting facts, feelings, and meaning by words, gestures, or other action. Communication may be verbal or nonverbal, and both are important.

4. Examination: Evaluation of a patient's physical self by an active process.

5. Interview: Goal-directed method of communication.

6. Symptom: Some condition present which shows evidence of disease or of a patient's state.

UNIT 1: COMMUNICATION SKILLS

The purpose of this unit is to introduce the student to some general forms of communication styles. In order to be effective in communicating an individual must be aware of his/her own style of communicating. It is also necessary to know which type of communication style is more effective in various situations.

Goals

1. The student will understand the process of communication.
2. The student will understand the meaning and differences of verbal and non-verbal communication.
3. The student will understand the differences between therapeutic and nontherapeutic communication techniques.

Objectives: On a short-answer/quick-score written midterm exam the student will be able to do the following.

1. Define the term communication in 25 words or less.
2. List and define in 15 words or less the five functional components of the communication process.
3. Define in 15 words or less the terms verbal communication and non-verbal communication.
4. Given five types of therapeutic communication techniques the student will define them in 15 words or less.
5. Define seven given types of nontherapeutic communication techniques in 15 words or less.
6. Given five communication situations, determine if the technique used is therapeutic or nontherapeutic. In 15 words or less describe why the communication technique

is what you have chosen.

Assigned Media

Sundeen, Nurse-Client Interaction, ch 4, pp68-95.

Wlody, "Effective Communication Techniques", Nursing Management, Oct. 1981, pp.20-23.

Nurse-Patient Communication (cassette & filmstrip)

UNIT 2: INTERVIEWING AND NURSE-PATIENT RELATIONSHIPS

The purpose of this unit is to introduce the student to some helpful interviewing techniques. This includes both principles of interviewing and characteristics of an interviewer. This unit also will help the student understand and improve the relationship between the nurse and the patient.

Goals

1. The student will understand various forms of verbal response.
2. The student will understand actions which will make the interviewee more comfortable and enhance the interview situation.
3. The student will develop an understanding of attitudes which are effective to the nurse-patient relationship.

Objectives: On a short-answer/quick-score written midterm exam the student will be able to do the following.

1. Define in 15 words or less each of the five basic categories of verbal response present in any interaction between people.
2. Given five different statement and response situations, the student will correctly match them with the type of verbal response they represent; evaluative, hostile, reassuring, probing, or understanding.
3. Given an interviewing situation the student will list and explain in 25 words or less five actions which can be taken to make the interview session comfortable and productive.

4. Define in 25 words or less the following attitudes in a relationship: trust, empathy, caring or love, and autonomy.
5. The student will pick two of the above attitudes and write a situation requiring their use in 50 words or less.

Assigned Media

Bernstein, Interviewing, ch 1 & 2, pp.1-45.

Greenhill, Maurice H. Interviewing With A Purpose (copy in Learning Center)

Sundeen, Nurse-Client Interaction, ch 5, pp96-107.

Interview (video-tape cassette)

UNIT 3: HISTORY TAKING

The purpose of this unit is to help the student develop beginning skills in eliciting a health history from an individual.

Goals

1. The student will understand basic principles of effective skills to obtain pertinent data.
2. The student will learn to organize and record the information obtained for a history.
3. The student will be aware of all the necessary components of a history.

Objectives: On a short-answer/quick-score written midterm exam the student will be able to do the following.

1. Explain in 25 words or less the importance of role setting in a patient interview. Included must be at least three specific reasons.
2. Name five ways of obtaining specific information from a patient during the interview.
3. Name two dangers of asking questions which require "yes" or "no" answers.
4. List the three general sources of information necessary for an adequate patient assessment.
5. List four guidelines in the wording of the chief complaint of the patient.
6. Given examples of chief complaints, the student will pick three and write a laundry list question for each.
7. Describe in 10 words or less three kinds of information

that should be elicited and recorded with regard to the onset of a symptom.

8. Describe in 10 words or less six kinds of information that should be elicited with regard to the characteristics of a symptom.
9. Describe in 15 words or less the purpose of the patient's family history.
10. Describe in 15 words or less the purpose of the patient's past medical history.
11. Given eight components of a patient history the student will sequence them in approximate order.

Assigned Media

Bates, A Guide to Physical Examination, ch 1 & 2, pp 1-30

Stromborg, Primary Care Assessment, Unit 1, pp3-8

The Health History: The Overview (video-tape cassette)

Physical Diagnosis and History Taking (slide-tape)

UNIT 4: PSYCHOSOCIAL EVALUATION

The purpose of this unit is to help the student develop skills in eliciting and assessing a patient's psychosocial framework. This includes both the patients behavior and the family dynamics.

Goals

1. The student will understand principles of psychological assessment and their importance.
2. The student will develop beginning skills in assessing and evaluating a patient's behavior.
3. The student will understand and be able to assess the dynamics of the family unit in relation to the patient.

Objectives: On a written short answer/quick-score midterm exam the student will be able to do the following.

1. Match the following terms regarding a patients behavior with definitions given.

   coping mechanisms
   coping strategies
   defense mechanisms
   stressful event
   rational thought
   disordered thought
   nonverbal behavior
   feelings

2. List three forms of nonverbal behavior and describe in 10 words or less what behavior state of the patient each might be indicative of.
3. Describe in 25 words or less the significance of a psychiatric history.

4. Given the five major categories of a psychiatric history, describe each in 15 words or less.
5. List six areas to be assessed regarding family function.
6. State five ways in which family units become dysfunctional and give an example of each.
7. Define in 25 words or less the concept of the "identified patient".

Assigned Media

Bates, A Guide to Physical Examination, ch 19

Burton, G. "Families in Crisis-Knowing When and How to Help", Nursing 75, Dec. 1975, pp 36-43.

Dodds, Marilyn, "Assessing Mental Status", AJN, Sept 1978, pg 1500

Snyder, Joyce, "Elements of a Psychological Assessment", AJN, Feb. 1977, pp 235-239.

Psychosocial Assessment (video-tape cassette)

Psychosocial Asaptation to Illness (cassette & filmstrip)

Psychotherapeutic Interview (video-tape cassette)

UNIT 5: GENERAL SURVEY

The purpose of this unit is to introduce the student to skills basic to physical examination. In addition it will make the student aware of wha is included in a general physical survey.

Goals

1. The student will understand the principles of and be able to perform the techniques of observation, auscultation, palpation and percussion.
2. The student will be able to make a general survey of a patient and record pertinent data.

Objectives: On a written short answer/quick-score midterm exam the student will be able to do the following.

1. List four physical assessment skills and describe in 25 words or less how each is performed and used by the practitioner.
2. Define the following terms related to percussion in 10 words or less and state where you would expect to pick up these sounds on percussion.

   tympany
   hyperresonance
   resonance
   dullness
   flatness

3. Explain in 25 words or less what is meant by "general survey" and when it might be conducted.
4. List 10 things you may observe about a patient while taking his/her vital signs and examining his/her hands.

5. Given a picture of an individual the student will list at least five things which can be noted about the person which are related to either his physical or psychosocial framework.

Assigned Media

Bates, A Guide To Physical Examination, ch 5

Ford, L. "Head to Toe", The Canadian Nurse, Sept. 1976, pp. 105-106.

Jarvis, Carolyn, "Perfecting Physical Assessment, Part I", Nursing 77, May 1977, pp 28-29.

Wagner, Mary M. "Assessment of Patients With Multiple Injuries" AJN, Oct. 1972, pp 1822-1827.

Developing Skills in Observation (cassette & filmstrip)

Physical Exam (video-tape cassette)

Physical Examination (video-tape cassette)

UNIT 6: TESTS: INDICATION and RESULTS

The purpose of this unit is to familiarize the sutdent with various tests and procedures used in medical care. It includes understanding of indications for the tests and interpreting the results.

Goals

1. The student will develop a basic understanding of X-rays and their interpretation.
2. The student will develop an understanding of reasons for obtaining lab tests.
3. The student will develop beginning skills in interpretation of lab studies.

Objectives: On a written midterm exam of quick-score/ short answer items the student will be able to do the following.

1. List the four types of densities observed on X-ray film.
2. Describe in 15 words or less the difference between AP and PA direction of taking X-ray films.
3. Name the density category of:

   heart
   lung

4. Define in 15 words or less the silhouette sign.
5. Given a chest X-ray label correctly the following points.

   bone
   air
   fat
   water
   area of lung volume
   position of heart
   diaphragm

6. List four general purposes for laboratory studies.
7. List at least three things which should be considered when ordering lab tests.
8. Define in 15 words or less the terms: anisocytosis and poikilocytosis.
9. List the three forms of granulocytes.
10. State at least one condition for each that would cause an elevated level of eosinophiles, neutrophils, and monocytes.
11. Explain in 25 words or less a "shift to the left" in the WBC differential and its significance.
12. Given a list of 10 lab values for blood and urine tests done on an adult, state whether they are normal, high, or low values.

Assigned Media

Fowkes,& Humm, Clinical Assessment for the Nurse Practitioner, ch 4, pp 121-165.

Tinker, "Understanding Chest X-rays", AJN, Jan. 1976, pp 54-58

Bloodgases (video-tape cassette)

Diagnostic Techniques "I" (slide & tape)

Mid-Term Exam: Examples

The mid-term exam will be worth 200 points. It will be a combination of quick-score and short answer items. See the page on grading for an explanation of how scoring will be done. Numbers before each item show their point value. Examples of test items:

(5) 1. Define communication. (15 words or less)

(7) 2. List seven types of nontherapeutic communication techniques.

(4) 3. Read the communication situation below. Determine whether the response given is therapeutic or non-therapeutic and put the correct letter next to each.

A-therapeutic response

B-nontherapeutic response

Interviewee: "I feel so guilty that I did not bring my wife to the doctor sooner."

Interviewer response:

_____1. "Well you should be because she is very sick now".

_____2. "I know you must feel bad, but let's look ahead and try to get your wife better."

(10) 4. List and define (15 words or less) each of the five basic categories of verbal response present in any interaction between people.

(6) 5. From the list of chief complaints below pick three and write an appropriate laundry list question.

Headache
Dizziness
Diarrhea
Chest Pain
Vomiting
Abdominal Cramps
Blurred Vision

(4) 6. Name two dangers of asking questions which require "yes" or "no" answers.

(16) 7. Match the following definitions to the correct term.

____a.coping mechanisms	1.takes place in conscious awareness, monitored by reason and logic
____b.coping strategies	2.actions aimed at eliminating or minimizing a stressful event
____c.defense mechanisms	3.body cues
____d.stressful event	4.directed by unconscious factors, less affected by reality or logic
____e.rational thought	5.falsify reality and do not alter the stressful situation or help allay anxiety
____f.disordered thought	6.individual's awareness of himself
____g.nonverbal behavior	7.occurence that triggers unusual response by individual
____h.feelings	8.responses which are task and reality oriented

(10) 8. Give an example for each of the following ways in which family units may become dysfunctional.

1. power
2. individuality of members
3. perception of reality about family
4. acceptance of loss/separation
5. recognizing family mood

(12) 9. List four physical assessment skills and describe (25 words or less) how each is performed, and the meaning of each to the practitioner.

(15) 10. Match the following terms related to percussion with the definitions given and state one area where you would expect to pick up each sound on percussion.

___1. tympany	A. Bell-like percussion note
___2. hyperresonance	B. Lack of normal resonance
___3. resonance	C. Range of tone produced by percussion
___4. dullness	D. Lower in frequency and longer in duration
___5. flatness	E. Shorter, higher pitched

(20) 11. List 10 things you may observe about a patient while taking his/her vital signs and examining his/her hands.

(4) 12. List the four types of densities observed on X-ray film.

(20) 14. Indicate whether the lab values below are normal, high, or low for an adult.

A: Normal
B: High
C: Low

___1. Hgb 15
___2. Hct 38
___3. Platelet count 50,000
___4. WBC (UA) 1,000
___5. PMN 35
___6. Lymph 15
___7. K 2.7
___8. Blasts 15
___9. Na 135
___10. ph (blood) 7.56

(6) 15. State one condition for each that would cause an elevated level in:

1. Eosinophiles
2. Neutrophils
3. Monocytes

UNIT 7: ASSESSMENT OF INTEGUMENTARY SYSTEM

The purpose of this unit is to help the student develop an understanding of the Integumentary system. Also to help the student develop beginning skills in the examination and assessment of the integumentary system.

Goals

1. The student will be able to perform a thorough examination of the skin.
2. The student will be able to describe findings from the examination using proper terminology.

Objectives: On a written final exam of quick-score/ short answer items the student will be able to do the following. The student will also incorporate the following in the written complete history and physical and/or the demonstration physical performed in front of the instructor.

1. Name and describe in 10 words or less the characteristics of at least three primary lesions of the skin.
2. Define in 15 words or less a secondary skin lesion and name eight.
3. List four variations in skin color and select from a list of conditions given, one for each that could be the cause of the variation.
4. Match the following with their correct definition from a given list.

cherry angioma
spider angioma
venous star
petechiae
ecchymosis

5. Describe in 10 words or less where you would look for petechiae if you had reason to suspect their presence.

6. State where you would inspect a patient with dark skin for the presence of true jaundice.

7. Define in 15 words or less what skin turgor means and list three ways you would check for it.

8. Describe in 10 words or less how you would detect the following in dark skinned people.

pallor
inflammation
cyanosis

Assigned Media

Bates, A Guide To Physical Examination, ch 6

Roach, Lora B. "Assessing Skin Changes", Nursing 74, March 1974, pp 64-67.

Diagnosing Common Small Skin Lesions (Video-tape cassette)

Physical Assessment of the Skin and Extremities (slide & tape, parts I, II, III).

UNIT 8: ASSESSMENT OF HEAD AND NECK

The purpose of this unit is to introduce the student to beginning skills in examination of the head and neck.

Goals

1. The student will have beginning skills in observational and manipulative skills in making a physical assessment of the head and neck.
2. The student will develop skills in using the otoscope and opthalmoscope.
3. The student will have the ability to differentiate normal findings in the head and neck from abnormal findings which require follow-up.

Objectives: On a written final exam of quick-score/short answer items the student will be able to do the following. The student will also incorporate the following in the written complete history and physical and/or the demonstration physical performed in front of the instructor.

1. In observing the skull, list two general observations which should be included and state two abnormalities for which the examiner searches.
2. Name and describe in 10 words or less two abnormal appearances of the face.
3. List the three parts of the ear.
4. Name five characteristics of the auricle or pinna which should be noted during the examination.

5. List the three important points in using the otoscope.
6. Describe in 10 words or less the appearance and color of the normal tympanic membrane as seen through an otoscope.
7. Differentiate in 15 words or less conductive and sensorineural hearing loss and give three causes for each.
8. Name the two paranasal sinuses which are accessible to clinical examination.
9. Name four abnormal findings which could be discovered in a nasal examination.
10. Demonstrate a systematic method of examining the mouth and pharynx and list the equipment needed for this procedure.
11. List six specific observations which should be made of the teeth and gums and buccal mucosa.
12. Name four specific observations which should be made of the tongue.
13. List five characteristics of oral lesions which may indicate malignancy.
14. Describe in 15 words or less how you would interpret the results of the Snellan Eye Chart Test for visual acuity.
15. On a simple diagram of the eye label the following.

medial canthus
limbus
bulbar conjuctiva
punctum
lacrimal gland
cornea
lateral canthus

16. Demonstrate proper technique of using the opthalmoscope in examining the following.

    pupillary reaction to light
    pupillary accommodation to light
    red reflex
    blood vasculature
    fundus

17. Given a list of things to examine in the eye, order them in proper sequence.

18. Identify the following eye conditions from photographs.

ptosis	marginal blepharitis
hordeolum	dacryocystitis
pyerygium	iritis
chalazion	cataract
entropion	edema of the lid
strabismus	exophthalmos

19. Demonstrate inspection of the neck including the following.

    lymph nodes
    trachea
    thyroid

20. Name one condition which would cause the trachea to deviate to one side.

21. Name two abnormalities for which the examiner would search in the palpation of the thyroid.

Assigned Media

Bates, A Guide to Physical Examination, ch 7.

Keough & Niebel, "Oral Cancer Detection-A Nursing Responsibility", AJN, April 1973, pp 684-686.

Schweiger, J.L., Schweiger, J.W., & John W. Lang, "Oral Assessment: How to Do It", AJN, April 1980, pp 654-657.

Stromborg, Primary Care Assessment, ch 28

General Ocular Examination (cassette & slide)

Physical Assessment of the Head and Neck (video-tape cassette)

UNIT 9: ASSESSMENT OF THE THORAX AND LUNG

The purpose of this unit is to introduce the student to beginning skills in examination and interpretation of findings for the thorax and lung.

Goals

1. The student will develop beginning skills in examining the thorax and lung using the techniques of inspection, palpation, percussion, and auscultation.
2. The student will be able to differentiate normal findings from those that are abnormal and require follow-up.

Objectives: On a written final exam of quick-score/short answer items the student will be able to do the following. The student will also incorporate the following in the written complete history and physical and/or the demonstration physical performed in front of the instructor.

1. Label the following on either a diagram or an individual.

   manubrium of sternum
   body of sternum
   suprasternal notch
   xiphoid process
   costal margin
   costal angle
   floating ribs
   7th cervical spinous process

2. Describe in 15 words or less the most desirable position for a patient in examining the posterior and anterior chest.
3. Locate on a chart or person the following.

A. Anterior view

1. midsternal line
2. left midclavicular line
3. left anterior axillary line

B. Right lateral view
1. anterior axillary line
2. midaxillary line
3. posterior axillary line

C. Posterior view
1. vertebral line
2. scapular line

4. List eight things you would assess on inspection of the chest (anterior/posterior).

5. List the four functions of palpation on the chest.

6. Demonstrate the proper technique for percussion of the chest both anterior and posterior.

7. List the five percussion notes and tell location of tissue where these would normally be found.

8. List three purposes for auscultation of lungs.

9. List the three types of breath sounds and where they would be heard in the normal patient.

10. Match the following with their correct definition.

tachypnea
hyperpnea
Cheyne Stokes respiration
rales
rhonchi
pleural friction rubs
bronchophony
egophony
pectoriloquy

11. List normal respiratory rates for the following.

adults
newborn
child (aged 1o)
child (aged 2)

12. List four indirect methods which are reliable indicators of respiratory functioning.

Assigned Media

Bates, A Guide to Physical Examination, ch 8, pp 112-138

Stromborg, Primary Care Assessment, Unit III, pp 34-66

Sweetwood, Hannelore, "Bedside Assessment of Respirations", Nursing 73, Sept. 1973, pp 50-51

Exam of Thorax and Lungs (video-tape cassette)

Inspection and Palpation of the Lungs and Thorax (film & cassette)

Percussion and Auscultation of the Lungs and Thorax (film & cassette)

Thorax (video-tape cassette)

UNIT 10: ASSESSMENT OF THE HEART

The purpose of this unit is to introduce the student to beginning skills in examination and interpretation of the heart.

Goals

1. The student will develop beginning skills in examining the heart.
2. The student will be able to differentiate normal findings from those that are abnormal and require follow-up.

Objectives: On a written final exam of quick-score/short answer items the student will be able to do the following. The student will also incorporate the following in the written complete history and physical and/or the demonstration physical performed in front of the instructor.

1. On a chart or diagram locate the following.

   inferior and superior vena cavae
   four chambers of the heart
   mitral, aortic, pulmonic, and tricuspid valves
   pulmonic vein and artery
   base and apex of the heart

2. Locate on your lab partner the PMI or apical impulse.
3. Define the following in 10 words or less and state an assessment technique used to diagnose each sign.

   lift
   heave
   thrill

4. Explain each of the following heart sounds in 15 words or less and state which are normal and which are not.

   S_1, S_2, S_3, S_4

5. Name the five parameters used in the recording of a heart murmur.

6. Describe in 10 words or less the four mechanisms which may cause heart murmurs.

7. Match characteristics given with the following conditions.

   mitral insufficiency
   mitral stenosis murmur
   aortic insufficiency
   aortic stenosis murmurs

8. Define in 15 words or less the term pulse pressure.

9. List five factors which influence arterial pressure.

10. List three factors which determine venous pressure.

Assigned Media

Bates, A Guide to Physical Examination, ch 9 & 10 pp 139-185

Stromborg, Primary Care Assessment, Unit II, pp 7-38

Auscultatory Analysis of Heart Sounds and Murmurs (tape & booklet)

Examination of the Heart (slide & tape)

Initial Assessment of the Heart (film & cassette)

Heart (video-tape cassette)

UNIT 11: ASSESSMENT OF BREAST, AXILLAE, AND ABDOMEN

The purpose of this unit is to introduce the student to beginning skills in examination and interpretation of the breast, axillae, and abdomen.

Goals

1. The student will develop beginning skills in observation and manipulation for physical assessment of the breast, axillae, and abdomen.
2. The student will be able to differentiate normal findings from those that are abnormal and require follow-up.

Objectives: On a written final exam of quick-score/short answer items the student will be able to do the following. The student will also incorporate the following in the written complete history and physical and/or the demonstration physical performed in front of the instructor.

1. Locate and describe the location in 10 words or less of each of the following on a diagram or individual.

   central axillary lymph nodes
   pectoral (anterior) lymph nodes
   subscapular (posterior) nodes
   infra and supra clavicular lymph nodes

2. List five things you look for on inspection of the breasts.
3. List five things you look for on inspection of the nipples.
4. List seven things you look for in examining a nodule.
5. Locate on a diagram or lab partner the following

RUQ	epigastric region
RLQ	umbilical region
LUQ	suprapubic region

6. List three structures felt in the lower abdomen occasionally which are often mistaken for tumors.
7. List six things the examiner can do to help the patient relax while doing an abdominal examination.
8. Sequence the procedures of inspection, percussion, palpation, and auscultation properly for an effective exam of the abdomen.
9. List 10 things you look for on inspection of the abdomen.
10. Explain in 15 words or less why auscultation is done prior to percussion and palpation of the abdomen.
11. Explain in 15 words or less the purpose for deep palpation of the abdomen.
12. Demonstrate two methods of palpating the liver.
13. State the length of time you should listen with your stethoscope in checking for bowel sounds, before you decide there are none.
14. Given a list of six abdominal organs state which abdominal quadrant they lie in.

Assigned Media

Bates, A Guide for Physical Examination, ch 11 & 12

Malkieivicz, J. "For A Really Thorough Abdominal Exam...", RN, Oct. 1982, pp 58-63

Stromborg, Primary Care Assessment, Unit IV, pp 67-100

Physical Assessment of the Breasts (video-tape cassette)

Physical Assessment of the Abdomen (video-tape cassette)

UNIT 12: ASSESSMENT OF THE BACK, EXTREMITIES, AND MUSCULOSKELETAL SYSTEM

The purpose of this unit is to introduce the student to beginning skills in examination and interpretation of the back, extremities, and musculoskeletal system.

Goals

1. The student will develop beginning skills in observation and manipulation for physical assessment of the back, extremities, and musculoskeletal system.
2. The student will be able to differentiate normal findings from those that are abnormal and require follow-up.

Objectives: On a written final exam of quick-score/short answer items the student will be able to do the following. The student will also incorporate the following in the written complete history and physical and/or the demonstration physical performed in front of the instructor.

1. Describe in 10 words or less five observations to make during inspection and palpation of the arms and legs.
2. Locate on your partner or a diagram the following.

   temporomandibular joint
   radius and ulna
   carpals and metacarpals
   proximal, distal, and middle phalanges
   medial and lateral epicondyles of the humerus
   patella
   achilles tendon
   cervical, thoracic, and lumbar curvatures

3. Define in 15 words or less tenosynovitis.
4. Name six abnormalities which may be found in the feet and toes.

5. Demonstrate examination of the following areas: (include ROM of appropriate joints)

   shoulder, upper arm, elbow, wrist, hand, and fingers
   hip, upper leg, knee, lower leg, ankle, and foot
   neck and spine

6. Demonstrate on your partner maneuvers for testing for the following.

   herniated lumbar disc
   sacroilliac pain

7. Match the following with the proper definition.

   lordosis
   kyphosis
   gibbus
   scoliosis

8. List the five "P's" to be used as a guide in the assessment of the nerve and circulatory status of a patient with an orthopedic injury.

Assigned Media

Bates, A Guide to Physical Examination, ch 17

Malkiewicz, J. "A Pragmatic Approach to Musculoskeletal Assessment", RN, Nov. 1982, pp 56-62

Stromborg, Primary Care Assessment, Unit IV, pp 131-184

Webb, K. "Early Assessment of Orthopedic Injuries", AJN, June, 1974, pp 1048-1052

Examination of the hand, wrist, and elbos (video-tape cassette)

Musculo-skeletal (video-tape cassette)

UNIT 13: NEUROLOGICAL ASSESSMENT

The purpose of this unit is to introduce the student to beginning skills in examination and interpretation of the neurological system.

Goals

1. The student will develop beginning skills in the physical examination of the neurological system.
2. The student will be able to differentiate between normal findings and abnormal ones which require follow-up.

Objectives: On a written final exam of quick-score/short answer items the student will be able to do the following. The student will also incorporate the following in the written complete history and physical and/or the demonstration physical performed in front of the instructor.

1. List three purposes of neurological examination.
2. List three higher level motor pathways that may affect reflex activity.
3. List the five major components of a neurological examination.
4. State the segmental levels of the following reflexes.

biceps	ankle
supinator	abdominal-upper and lower
tricepts	cremasteric
knee	plantar

5. Describe in 20 words or less the difference between superficial reflexes and deep tendon reflexes.

6. Demonstrate on your partner how you would test for the motor and sensory function of the 12 cranial nerves.

7. Demonstrate on your partner three procedures to use in screening for sensory disorders.

8. Demonstrate on your partner how you would test for discriminative sensation, using:

   stereognosis
   point localization
   extinction
   2 point discrimination

9. Demonstrate on your partner the method for testing the following reflexes.

   biceps
   triceps
   brachloradialis
   abdominal
   knee
   ankle

10. Match the following terminology with definitions given.

dysarthria	chorea
cerebellar dysarthria	athetosis
coma	myoclonus
nystagmus	cerebellar ataxia
fasciculations	sensory ataxia
tics	parkinsonian gain

11. Match signs and symptoms given with the following neurological lesions.

pyramidal	posterior column
extrapyramidal	spinothalamic
cerebellar	sensory cortex
peripheral sensory	

Assigned Media

Bates, A Guide for Physical Examinatinn, ch 18 & 19

King, R.C. "Checking the Patient's Neurological Status", RN, Dec. 1982, pp 56-62

Stromborg, Primary Care Assessment , ch 27, 29, & 30

Essestials of Neurological Exam (video-tape cassette)

Physical Assessment of the Neurological System (video-tape cassette)

UNIT 14: ASSESSMENT OF GENITO-URINARY

The purpose of this unit is to introduce the student to beginning skills of observation and manipulation in the examination and interpretation of the genito-urinary system.

Goals

1. The student will develop beginning skills in observation and manipulation in the examination of the genito-urinary system.
2. The student will be able to differentiate normal findings from those abnormal ones which require follow-up.

Objectives: On a written final exam of quick-score/short answer items the student will be able to do the following. The student will also incorporate the following in the written complete history and physical and/or the demonstration physical performed in front of the instructor.

1. Label on a diagram the following.

testes	vas deferens
epididymis	spermatic cord
scrotum	shaft, corona, glans and prepuce
tunica vaginalis	of the penis
urethral meatus	

2. List two features of each that differentiate an indirect inguinal hernia, a direct inguinal hernia, and a femoral hernia.

3. Label on a diagram the following.

mons pubis	perineum	fallopian tube
prepuce	hymen	uterus
urethral orifice	vagina	bladder
opening of skene's gland		cervix

4. List six methods to help a patient relax for a vaginal exam.

5. Describe in 10 words or less the following types of discharge.

   trichomonas
   monilia (candida) vaginitis
   early gonorrhea
   senile vaginitis

6. Given descriptions of various palpated masses in the abdomen, determine if they are adnexal masses, ovarian cysts, tumors, pelvic inflammatory disease, or ruptured tubal pregnancy.

7. Label the following on a given diagram.

   anal margin
   anal canal
   anorectal junction
   rectum
   prostate
   peritoneal reflection
   external sphincter
   internal sphincter

8. Describe in 25 words or less the difference between internal and external hemorrhoids.

9. Name the five characteristics of the uterus which require observation and recording.

Assigned Media

Bates, A Guide for Physical Examination, Ch 13, 14, 15

Kolckeritz, J. "Assessing the Genitalia", RN, Jan. 1983, pp 52-59

Stromborg, Primary Care Assessment, Unit V & VIII

Female Pelvic Exam (video-tape cassette)

Male Genitalia, Anus, and Rectum (video-tape cassette)

Physical Assessment of the Genito-urologic System (video-tape cassette)

UNIT 15: ASSESSMENT OF PEDIATRICS

The purpose of this unit is to help the student become aware of the normal findings in examination of a child and how these are different from an adult. The student will also learn differences in the methods of examining a child.

Goals

1. The student will be aware of those findings which are normal for a child at various ages.
2. The student will be able to differentiate normal findings from abnormal findings which require follow-up.

Objectives: On a written quick-score/short answer final exam the student will be able to do the following.

1. List the average pulse rates and respiratory rates for infants in the first six months, early childhood (age 1-6), and late childhood (age 6-10).
2. List three common dermatological conditions seen in neonates.
3. Discuss in 25 words or less the significance of head measurements.
4. List "normal" visual acuity for age 3, 5, and 7.
5. List the thoracic index of the child at birth, one year, and six years.
6. Name two common arrhythmias normally found in children.
7. Name the two conditions which generally cause heart murmurs in children.
8. List three findings that would indicate the presence of CNS disease in infants.

9. Match the following tests with the correct description from a given list.

Hirschberg test
Flush method (B/P)
Ortolani's test
Denver Developmental Screening Test

Assigned Media

Bates, A Guide for Physical Examination, ch 21 & 22

Pediatrics (video-tape cassette)

Pediatric Nursing Assessment- The Interview (video-tape cassette)

Taking a Health History from a Parent and Child (video-tape cassette)

Final Exam

The final exam is worth 200 points. It is not cummulative but knowledge of the first half of the semester is needed for a base. It will be a combination of quick-score and short answer items. See the page on grading for an explanation of how scoring will be done.

Examples of test items:

(9) 1. Name and describe (10 words or less) characteristics of three primary lesions of the skin.

(10) 2. For each skin color variation given, list one condition which could be the cause.

1. brown
2. blue (cyanosis)
3. red
4. yellow jaundice
5. reddish blue

(10) 3. Match the following skin lesions with the proper definition.

___1. cherry angioma
___2. spider angioma
___3. venous star
___4. petechiae
___5. ecchymosis

A. round and flat, deep red
B. central raised body with radiating legs
C. round, partial blanching, increased number with age
D. blood extravasated outside vessels, often secondary to trauma
E. most often in legs, accompanies varicose veins

(3) 4. List the three parts of the ear.

(6) 5. List six specific observations which should be made of the teeth, gums, and buccal mucosa.

(10) 6. Label the following on the diagram given.

1. medial canthus

2. limbus
3. punctum
4. cornea
5. lacrimal gland

(16) 7. List eight things you would assess on inspection of the chest.

(20) 8. Match the correct definition with each of the following.

___1. tachypnea	A. hyperventilation
___2. hypernea	B. slow breathing
___3. Cheyne Stokes	C. increased intensity and clarity of spoken voice sounds through stethescope
___4. rales	
___5. rhonchi	
___6. pleural friction rubs	D. unusually clear transmission of whispered words through stethescope
___7. bronchophony	
___8. egophony	
___9. pectoriloquy	E. crachles
___10. bradypnea	F. rapid shallow breathing
	G. two roughened pleural surfaces rub across each other
	H. deep breathing alternating with apnea
	I. low wheezes
	J. nasal bleating quality of voice sounds

(6) 9. List where in the lung these normal breath sounds would be auscultated.

1. vesicular
2. bronchovesicular
3. bronchial/tubular

(8) 10. List normal respiratory rate for the following.

1. adult
2. newborn
3. child (aged 2)
4. child (aged 10)

(10) 11. Name the five parameters used in the recording of of a heart murmur.

(12) 12. On the diagram given label the following.

1. right upper quadrant (RUQ)
2. right lower quadrant (RLQ)
3. left upper quadrant (LUQ)
4. Epigastric region
5. umbilical region
6. suprapubic region

(10) 13. List the five "P's" to be used as a guide in the assessment of the nerve and circulatory status of a patient with an orthopedic injury.

(12) 14. List six methods to help a patient relax for a vaginal exam.

Taped History

The purpose of this assignment is to allow the student to integrate communication skills and the techniques of medical history taking. By video-taping this the student will be able to review his/her own techniques and discover strengths and weaknesses.

Instructions

1. Sign up for a time to be videotaped.
2. This assignment must be completed during either week five or week six.
3. Select a peer to role play your patient.
4. Just prior to taping obtain a chief complaint slip of paper from the Learning Center staff.
5. Utilize the history-taking information given in class and from the readings.
6. Videotape for 15 to 20 minutes, budgeting half the time for the chief complaint and half the time for patient profile, personal habits, and mental status.
7. Sign up for a time to critique and evaluate the tape with the instructor.

**8. Read the instructions in the taping room carefully before you begin the use the video equipment. If you have any questions ask in the Learning Center.

Evaluation and Grading

The student will meet with the instructor and evaluate the tape according to its content and effectiveness in the

following areas. Grading is done on a pass/fail basis. If you pass 85% of the areas you receive full credit (100%) for the assignment. If you fail than arrangements must be made to do another videotaped session. You may repeat the taping two times in order to obtain a pass level.

Areas Evaluated

1. Introduction
   a. purpose of history
   b. nurse-patient roles
   c. length of interview
2. Rapport and sensitivity
   a. develops comfortable atmosphere
   b. non-judgemental toward patient responses
   c. exhibits confidence
3. Comprehensive exploration
   a. exploration of chief complaint
   b. pertinent and complete
4. Stress component of chief complaint
   a. recognize and explore psychological cues
5. Terminology
   a. clarification
   b. appropriate to patient level
6. Transitions
   a. explanation given to patient
   b. smooth subject change
   c. redirects patient when necessary

7. Verbal and non-verbal patient messages

   a. responds to patient cues

   b. comment on non-verbal messages

Guidelines for Complete History and Physical

The purpose of this assignment is to pull together all of the skills you have learned throughout the semester: history taking, examination, and assessment skills.

Instructions

1. Select an individual (friend, relative, patient) on whom you will take an history and perform a physical.
2. Use the following formats for your recording:
   "The Patient History- form #1"- class handout
   "Recording the Physical Exam"- Bates, ch. 4
3. This assignment has three parts. 1. History, 2. Physical exam, and 3. Problem list.
4. Use information from media and lectures for your knowledge base.
5. The assignment will be graded according to the format which follows.
6. This assignment is due week 16 of the semester.
   HINT: Start this assignment early as the write-up can become very time-consuming.
7. See the instructions on grading to determine how this assignment fits into your overall course grade.

Evaluation and Grading

	Point Value
1. Format and organization in recording	20
2. Completeness and accuracy of data	40
3. Use of correct terminology	15

4. Problem list development	15
5. Integration of various concepts in plan	20
6. Personal habits	20
intake	
drugs	
work	
rest	
recreation	
diet	
exercise	
7. Patient profile	40
family	
education	
work	
social	
sexual	
coping style	
talents/strengths	
8. Mental status	30
appearance	
affect	
thought process	
thought content	
perception	
judgement	
insight	
memory	
orientation	

Total points- 200

Guidelines for Demonstration

Physical Examination

The purpose of this assignment is to give the student an opportunity to demonstrate the physical examination/ assessment skills which you have learned.

Instructions

1. This demonstration will take place during one hour of the three hour final session.
2. Pick a partner on whom you will perform the exam.
3. Four weeks prior to doing this the student will receive a handout from the instructor. The handout will list what is to be covered on the physical exam. It will be the same form used for evaluating the demonstration.
4. Each of the 50 items on the evaluation will be worth two points. Total points possible- 100.
5. See the instructions on grading to determine how this assignment fits into your overall course grade.

GRADING

Grades for Nursing 450 will be determined by the following activities:

Video-taped history	10%
Mid-term exam	25%
Complete history and physical	25%
Demonstration physical	15%
Final exam	25%
Total	100%

Each activity will be assigned a point value related to the percentage value attained.

For example:

200 point mid-term

student score- 180

percent correct- 90%

point value given- 90

At the completion of the course the points will be put toward your final score as indicated by the percentages given above. The final grade will be determined by the scale below:

A: 93-100

B: 85-92

C: 75-85

Note: Any student receiving a course grade of less than a C must consult with his/her counselor and obtain permission to repeat the class. This course may only be repeated one time.

Example of grading

Pupil A	Score	Percent	Points
Video-taped history		100%	10
Mid-term exam	190	95%	23.75
History and physical	180	90%	22.5
Physical demonstration	100	100%	15
Final exam	180	90%	22.5
		Total	93.75
		Grade	A

Class Evaluation and Revision

At the completion of this course the student will be asked to fill out an evaluation form. Please do so thoughtfully and carefully as the instructor uses this information to make revisions. Also, please feel free throughout the semester to question the teacher or make suggestions about aspects either confussing or not helpful within the course.

After each semester the results and suggestions are recorded. After three semesters the instructor meets with the curriculum committee to review all the information. Together it is decided what areas of the course need revision and suggestions are made for how to make the changes. In doing this we hope to create and maintain a course which is worthwhile and timely.

Bibliography

Communication

Myers, G.E., & Myers, M.T., The Dynamics of Human Communication, McGraw-Hill, Inc., New York, NY, 1976

Interviewing

Bernstein, Interviewing, ch 3-7, pp 46-128.

Jasmin, S. & Trygstad, L.N., Behavioral Concepts and the Nursing Process, C.V. Mosby Co., New York, NY, 1979, ch 3, pp 30-46.

Psychosocial Evaluation

Stalemate-Select Patterns of Maladaptive Behavior (film)

Reinhardt, Adina, & Mildred Quinn, Family-Centered Community Nursing, McGraw-Hill, Inc., New York, NY, 1979, ch 9, 13, 14, 15.

Family Therapy: Problem Identification (video-tape cassette)

Head and Neck

AJN Programmed Instruction, "Patient Assessment: Exam of the Ear", AJN, March 1975.

Sucher, & Sakamoto, Physical Assessment Module #3: Head and Neck, & Module #4: Eye

Differential Diagnosis of Oral Lesions (video-tape cassette)

Physical Assessment of the Eye (video-tape cassette)

Physical Assessment of the Ear, Nose, and Throat (video-tape cassette)

Slide Tape set:
"Overview of Disk
"Introduction"
"Disk"
"Vessels"
"General Background"
"Macula"
"Summary"

Thorax and Lung

"Patient Assessment: Examination of Chest and Lungs", AJN Vol. 76 #9

Sucher & Sakamoto, Physical Assessment Module # 5: Thorax and Lungs

The Chest: Signs and Sounds (series of 12 cassettes & book)

Assessing Respirations (filmstrip & cassette)

Introduction to Breath Sounds (cassette)

Heart

"Patient Assessment: Auscultation of the Heart"Part II, AJN, Feb. 1977

Sucher & Sakamoto, Physical Assessment Module #6: Heart and A/V Pulses

Heart Sounds and Auscultation (cassette)

Pressures and Pulses (video-tape cassette)

Breast, Axillae, Abdomen

"Patient Assessment: Examination of the Abdomen", AJN, Sept. 1974, pp 1697-1702

Sucher & Sakamoto, Physical Assessment Module #7, Breast, Axilla, Abdomen

Abdomen (video-tape cassette)

Breast and Axilla (video-tape cassette)

Neurological

"Patient Assessment: Neurological Examination, Part I, II, and III", AJN, Sept. 1975, Nov. 1975, April 1976

Sucher & Sakamoto, Physical Assessment Module #8: Neurological

Neurologic System (video-tape cassette)

Genito-urinary

DeGowin, Elmer & Richard DeGowin, Bedside Diagnostic Examination MacMillan Co. New York, NY, 1969, ch 8, pp 531-551, & ch 9 pp 552-604

Sucher & Sakamoto, Physical Assessment Module #9: Lower GI and GU

Pelvic Exam (video-tape cassette)

Female Genitalia, Anus, and Rectum (video-tape cassette)

Male (video-tape cassette)

Inspection of vagina, cervix, and External Genitalis (slide and tapes)

Pediatrics

Assessment of Growth and Development (video-tape cassette)

The Measurement of Physical Growth (video-tape cassette)

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